Military Sexual Assault: The Current State of Policy, Screening, And Follow Up Care

Micheal Allen, Capt, NC, USAF; Alexander Kats, Capt, NC, USAF; Jennifer Prosser, Maj, NC, USAF
Daniel K. Inouye Graduate School of Nursing, Uniformed Services University of the Health Sciences, Bethesda, MD

Introduction

Definition: Sexual Assault (SA) is the forceful act of sexual aggression or violence on the continuum of rape to include unwanted kissing, fondling, groping, touching, or penetration of oral, anal, vaginal or penile, against a person, male or female, without prior consent

- 1.3 million SA per year in the U.S.
  - 28–33% prevalence for women
  - 11–18% prevalence for men
- 1.5% military members experience SA per year
  - 20,300 individuals in 2014
  - 4.9% female and 1% male
- 9.5-33% AD females experience SA while in service
- USAF
  - 10 female victims for every male service member

Military Sexual Assaults

- Under Estimated
- Under Reported
  - 6-25% report SA
- Under Screened
  - 0-25% screen in primary care
- Follow-up care lacking
  - In 2005, 812 women in a small Seattle hospital, only 35.5% sought f/u medical care
  - In 2015, of 207 OEF/OIF AD Females deployed, only 25% received f/u MH care and 16% sought f/u medical care

Arm 1: Accession Policies

Literature Review, Design, & Results

- Female SA
  - 79.6% occur before age 25
  - 42.2% before age 18
    - 35% re-assaulted as adults
- Females entering military service
  - 30% indicated SA prior to entering the military
  - 2-5 fold risk of re-victimization during military service
- Male SA
  - 27.8% before age 10
  - 6% indicated prior to entering the military
- Male history of sexual or physical abuse
  - One type alone, a 2 fold risk of perpetration in military
  - Both types, a 4-6 fold risk of perpetration in the military

Recommendations

Organizational Impact (All Arms)

Adverse consequences of SA include psychological, physical, and spiritual dysfunction. No Department of Defense or Air Force policy mandates SA screening during the accession period, despite a strong association in the literature between prior victimization and adverse outcomes in individuals with a history of SA. Military SA training can be improved to target specific reporting and screening barriers in effort to remove stigma, fears of reporting, and confidentiality concerns (among others). Many avenues for improving follow up care can be taken, such as efforts to perform appropriate lab work up at recognized timeframes and consideration for mental health consultation.

"The authors would like to acknowledge our DNP Project Mentors: Dr. Diane Seibert (Senior Mentor), Lt Col Brian Kittelson, Lt Col Laura Lewis, and Dr. Ann Burgess for their support, guidance, and assistance. Their time, effort, and dedication to this project is appreciated more than words can express."

Significance of the Problem

Sexual assault is associated with a number of sequelae that may affect the physical and mental health of victims. Many active duty military members are victims of sexual assault before or during their military service. Sexual assault screening policies, screening practices and sexual assault follow up care may impact the health of our military members.

Arm 2: SA Screening & Reporting

Literature Review and Design

- 1%-25% of PCPs routinely screen
- 11% screen annually
- 30% believe patients should be routinely screened
- Some do not view SA as a significant diagnosis

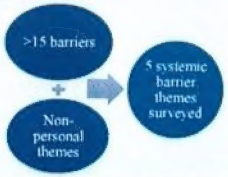
- Dozens of reporting barriers identified
  - Stigma barriers appear to be of most concern: shame, guilt, or embarrassment
- Other prevalent themes: fear of retaliation and confidentiality concerns
- Gender preference (most favor female providers)

- Many personal barriers
- View of SA as an insignificant medical condition
- Rape/Sexual Violence myth acceptance
- Demographic barriers (age, gender, language, ethnicity)
- Personal discomfort with the subject
- Inefficacy

Systemic barrier themes:

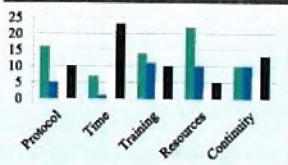
1. Protocol
2. Time
3. Training
4. Resources
5. Established patient-provider relationship

SURVEY DESIGN



Likert scale
- Concern for barriers measured on 1-4 scale
  - 1 = no concern
  - 2 = low concern
  - 3 = some more concern
  - 4 = significant concern

Results & Recommendations



Limitations:
- Many other barriers exist which need to be addressed
- Survey does not investigate provider attitudes toward SA
- Survey does not evaluate provider willingness to screen for SA

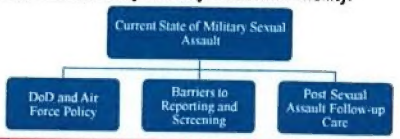
Analysis of Results
- Lack of time (Q2) most concerning: Average response = 3.2
- Lack of resources (Q4) least concerning: Avg response = 1.8
- 50% think lacking patient-provider relationship (Q5) is of concern
- Less than 50% think lacking protocol or training is an issue

Recommendations

"The views expressed in this poster are those of the authors and do not necessarily reflect the official policy or position of the Uniformed Services University of the Health Sciences, the Department of Defense, or the United States government."

Purpose and Project Design

Purpose: To explore the current state of: DoD screening policy for prior sexual assault history; barriers to reporting and screening of sexual abuse in primary care clinics; and sexual assault follow up care of the active duty member in a large ambulatory military treatment facility.



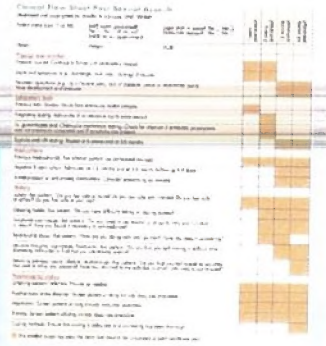
Arm 3: Follow Up Care

Literature Review and Design

- Retrospective Chart Review
- Clinical Flow Sheet Post Sexual Assault (Korkosz, 2014)
- MHS Management Analysis & Reporting (M2)
  - SA related ICD 9 code
  - Active Duty
  - Clinic on JBSA
  - MHS care for 6 months

- Gender
  - 1 male
  - 22 female
- Race
  - 12 white
  - 3 black
  - 2 Hispanic
  - 6 other/unknown
- Age
  - 18 less than age 17-24
  - 5 age 25-34
- 10 Trainees/13 Permanent

81 EHRs
58 EHRs did not meet criteria
23 EHRs



Results & Recommendations

Screen/Tx	1 WEEK	2 WEEK	1-2 MONTH	2-4 MONTH
Pregnancy				
GC/Chlamydia				
HIV/Syphilis			6 WK	3-6 MO
MH Pharm Consideration				
Safety				
Sleeping				
Substance		69%	82%	65%
MH Support	73%	63%	61%	65%
PTSD				
Depression		58%	65%	65%
Anxiety			52%	

= NA
<50%
>50%

92% 3+ appointments
47% SARC contact

Analysis of Results:
- No statistical difference in follow up care received by trainees and permanent party members
- Findings compared to literature
- Follow up care policy
- Further investigation & comparison to large NW MTF

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

MILITARY SEXUAL ASSAULT: THE CURRENT STATE OF POLICY, SCREENING, AND FOLLOW-UP CARE

CAPT MICHEAL P. ALLEN
CAPT ALEXANDER KATS
MAJ JENNIFER PROSSER

SENIOR MENTOR: DR. DIANE SEIBERT
SITE DIRECTOR: LTC BRIAN KITTELSON
PROJECT MEMBER: LTC LAURA LEWIS

JONAS CENTER
FOR NURSING AND
VETERANS HEALTHCARE
Improving Healthcare Through Nursing

2016 DOCTORATE OF NURSING PRACTICE PROJECT

DISCLAIMER

The views expressed in the power point do not necessarily reflect the policy of the Uniformed Services University, the Department of Defense, or the United States Government

INTRODUCTION

Sexual Assault (SA) is the forceful act of sexual aggression or violence on the continuum of rape to include unwanted kissing, fondling, groping, touching, or penetration of oral, anal, vaginal or penile, against a person, male or female, without prior consent

(Castro et al., 2015; Do, Schrager, & Gilchrist, 2010; The American College of Obstetricians and Gynecologists, 2014; WHO, 2012)

INTRODUCTION

- 1.3 million SA per year in the U.S.
  - 28–33% prevalence for women
  - 11–18% prevalence for men

(ACOG, 2014; Black et al., 2011; Burgess, Slattery, & Herlihy, 2013; Castro et al., 2015; WHO, 2012)

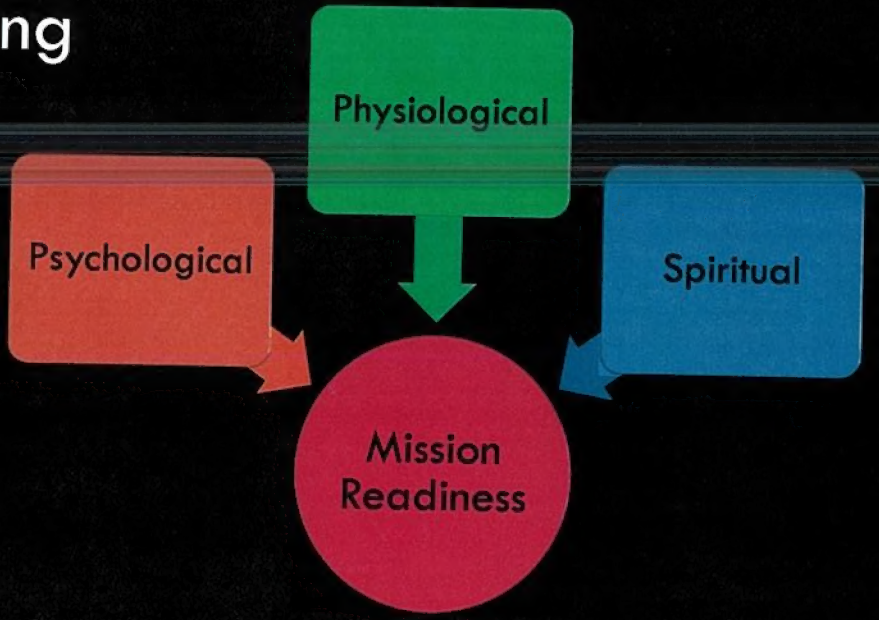
SIGNIFICANCE OF THE PROBLEM

- 1.5% military members experience SA per year
  - 20,300 individuals in 2014
    - 4.9% female and 1% male
- 9.5-33% AD females experience SA while in service
- USAF
  - 10 female victims for every male service member

(Burgess, Slattery, & Herlihy, 2013; DoD SAPR, 2015; "National Defense Research Institute", 2014)

SIGNIFICANCE OF THE PROBLEM

- Under-estimated, under-reported, & under-screened
- Follow-up post SA lacking
- Sequelae



CLINICAL QUESTIONS / ARMS

The Current State of

I. DoD screening policy for prior SA history
II. Barriers to SA reporting/screening in primary care
III. Follow-up care for SA in AD members in a large ambulatory MTF

ARM I Screening Accession Policies for Prior SA History

CAPT MICHEAL P. ALLEN

LITERATURE REVIEW

- Female SAs
  - 79.6% occur before age 25
  - 42.2% before age 18
    - 35% re-assaulted as adults

- Females entering military service
  - 30% indicated SA prior to entering the military
  - 2-5 fold risk of re-victimization during military service

(Black et al., 2011; Castro et al., 2015; Merrill, Thomsen, Gold, & Milner, 2001)

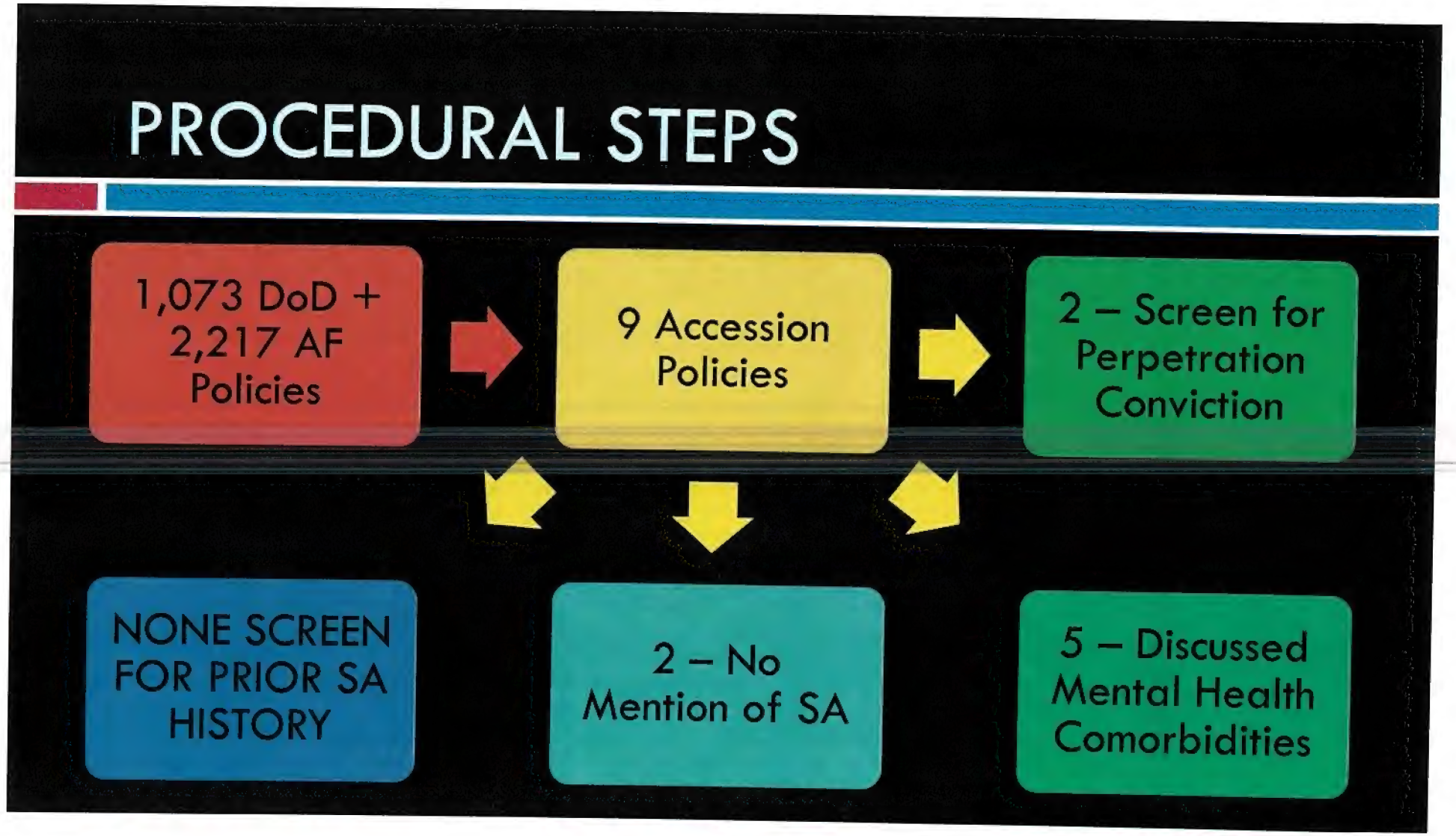
LITERATURE REVIEW

- Male SA
  - 27.8% before age 10
  - 6% indicated prior to entering the military

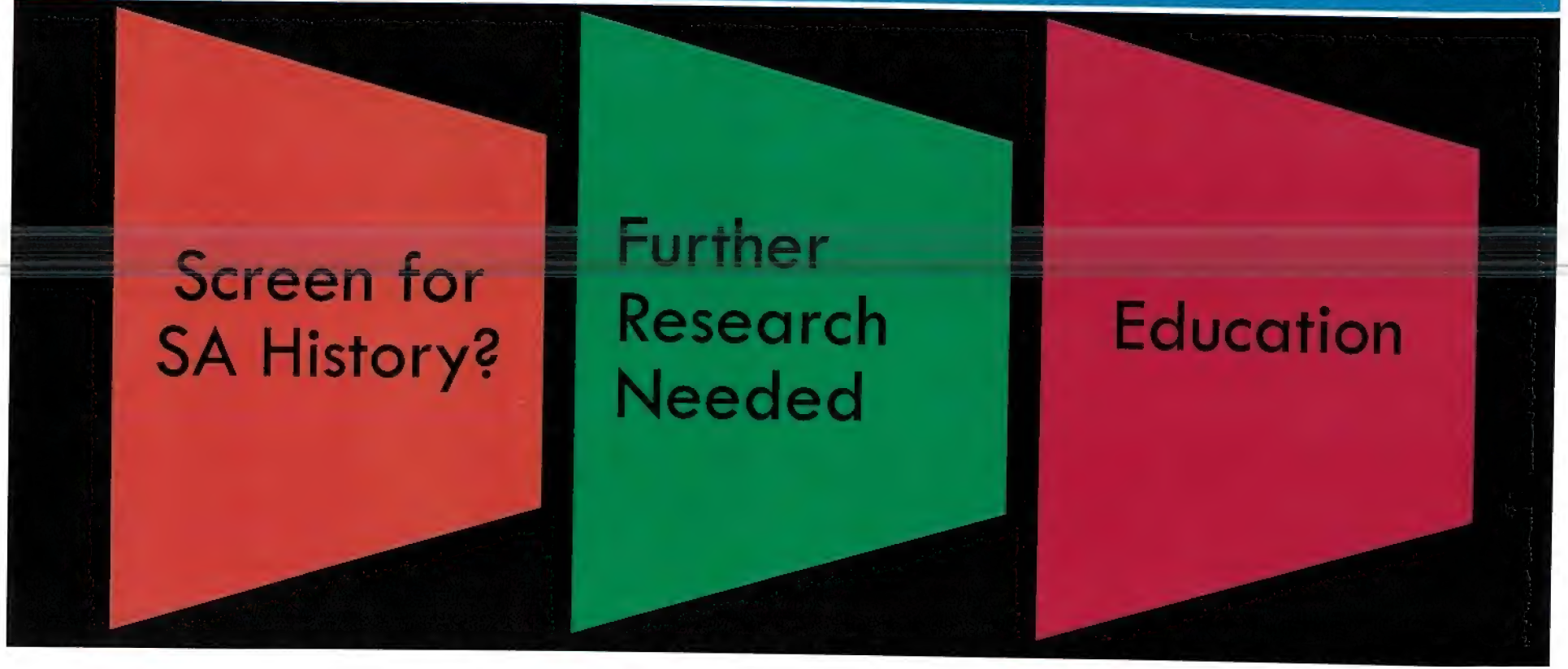
- History of sexual or physical abuse
  - One type alone, a 2 fold risk of perpetration in military
  - Both types, a 4-6 fold risk of perpetration in the military

(Black et al., 2011; Castro et al., 2015; Merrill, Thomsen, Gold, & Milner, 2001)

PROCEDURAL STEPS



RECOMMENDATIONS



ARM 2

Barriers to SA Reporting/Screening in Primary Care

CAPT ALEXANDER KATS

LITERATURE REVIEW

- 1%-25% of PCPs routinely screen
- 11% screen annually
- 30% believe patients should be routinely screened
- Some do not view SA as a significant diagnosis

(Stayton and Duncan, 2005; Waalen, Goodwin, Spitz, Peterson, & Saltzman, 2000; Friedman, Samet, Roberts, Hudlin, & Hans,1992)

PATIENT BARRIERS

- Dozens of barriers identified
  - Stigma barriers appear to be of most concern
    - Shame, guilt, or embarrassment
- Other prevalent themes: fear of retaliation and confidentiality concerns
- Gender preference (most favor female providers)

(Sable, Danis, Mauzy, & Gallagher, 2006; Mengeling et al., 2014; Steiger et al., 2010; Turchik et al., 2013)

PROVIDER BARRIERS

- Many personal barriers
  - View SA as an insignificant medical condition
  - Rape/Sexual Violence myth acceptance
  - Demographic barriers (age, gender, language, ethnicity)
  - Personal discomfort with the subject
  - Inefficacy
- Systemic barrier themes
  - Lacking: time, training, protocol, resources, established patient-provider relationship

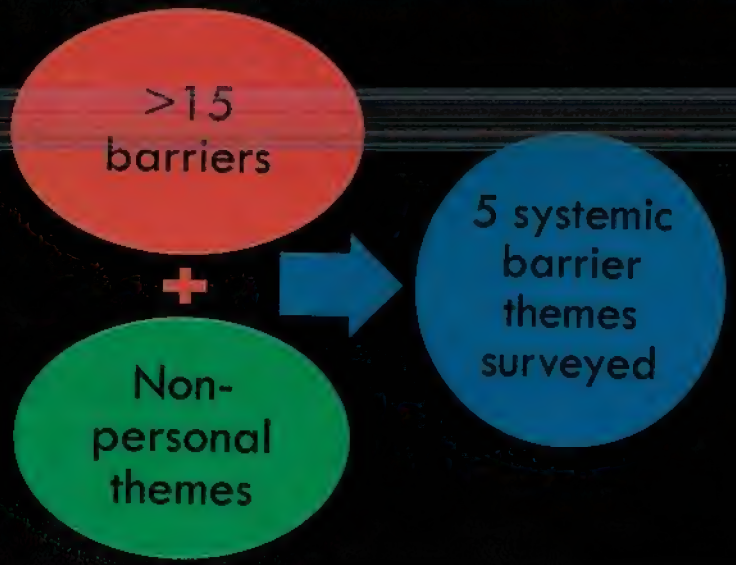
(Littleton et al., 2007; Rodriguez et al., 1999; Waalen et al., 2000; McGrath et al., 1997; Baig et al., 2012; & Sprague, Kaloty, et al., 2013)

PROCEDURAL STEPS

Literature Review: Screening Barriers

- Provider barriers: 11 articles (8 primary studies)
- Provider survey on systemic barriers

Survey Design



PROVIDER SURVEY

Q1: Lack of protocol

Q2: Lack of time

Q3: Lack of training

Q4: Lack of resources

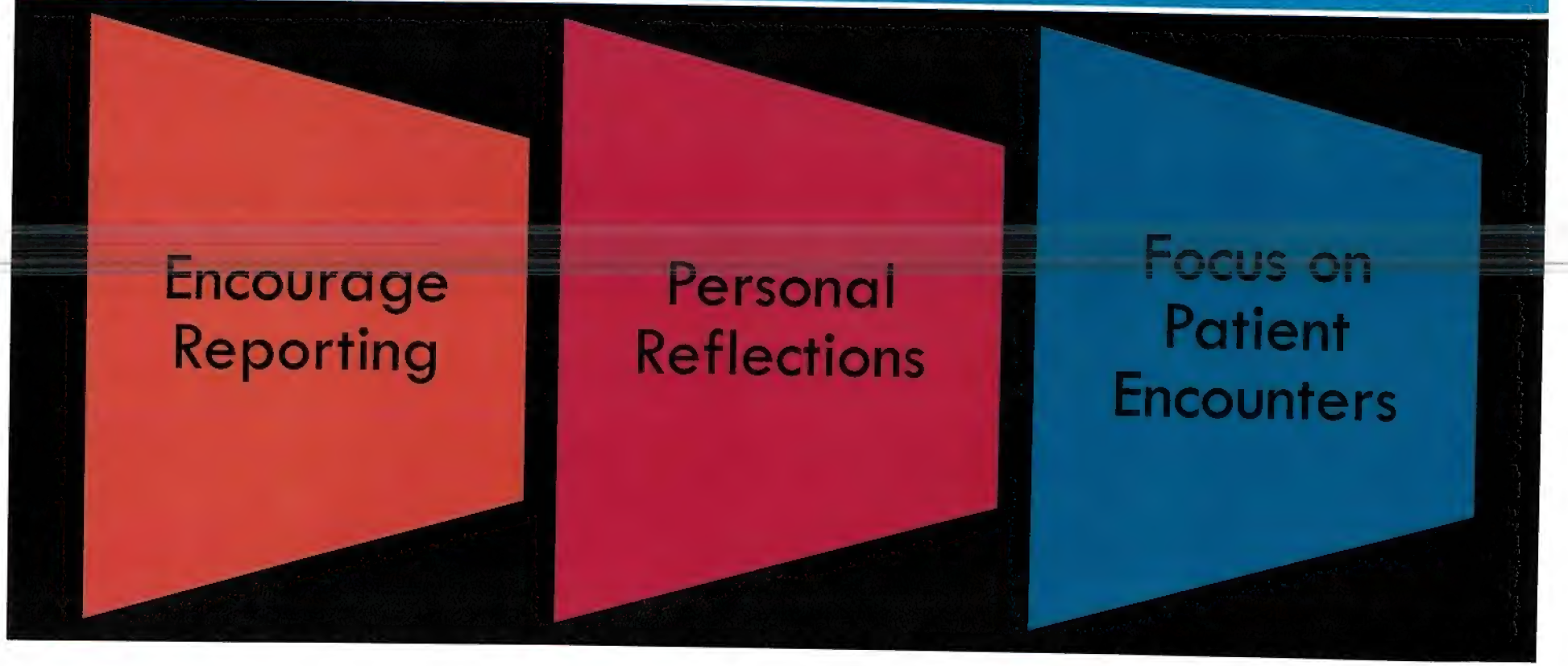
Q5: Lack of established patient-provider relationship

Likert scale used

- Concern for barriers measured on 1-4 scale
  - 1 = no concern
  - 2 = low concern
  - 3 = some more concern
  - 4 = significant concern

PROVIDER SURVEY RESULTS

RECOMMENDATIONS

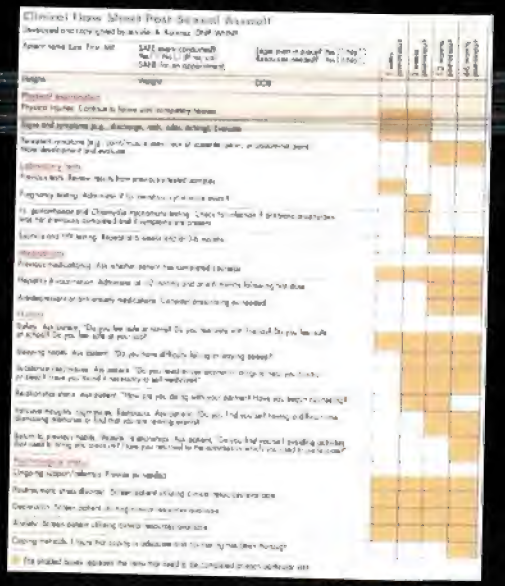


ARM 3 Post SA Follow-up Care for Military Members

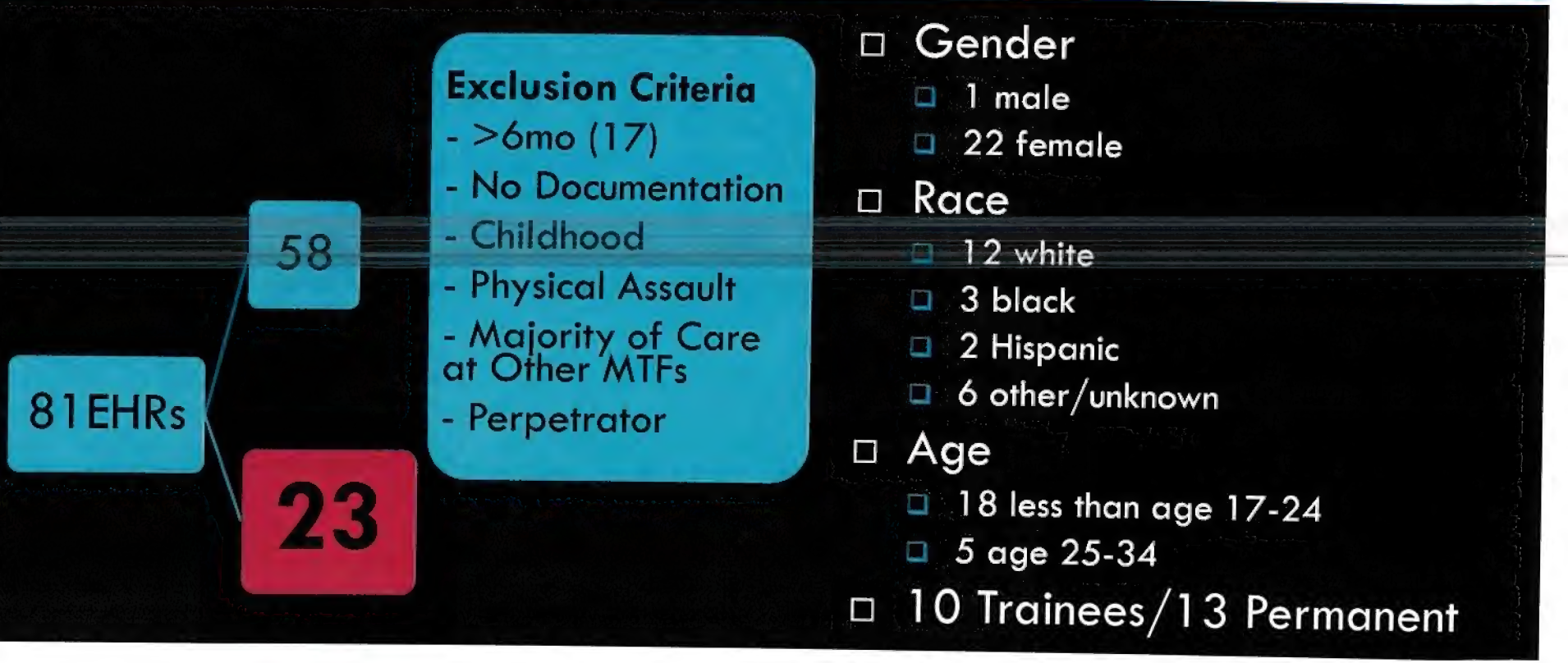
MAJ JENNIFER PROSSER

PROCEDURAL STEPS: FOLLOW-UP CARE

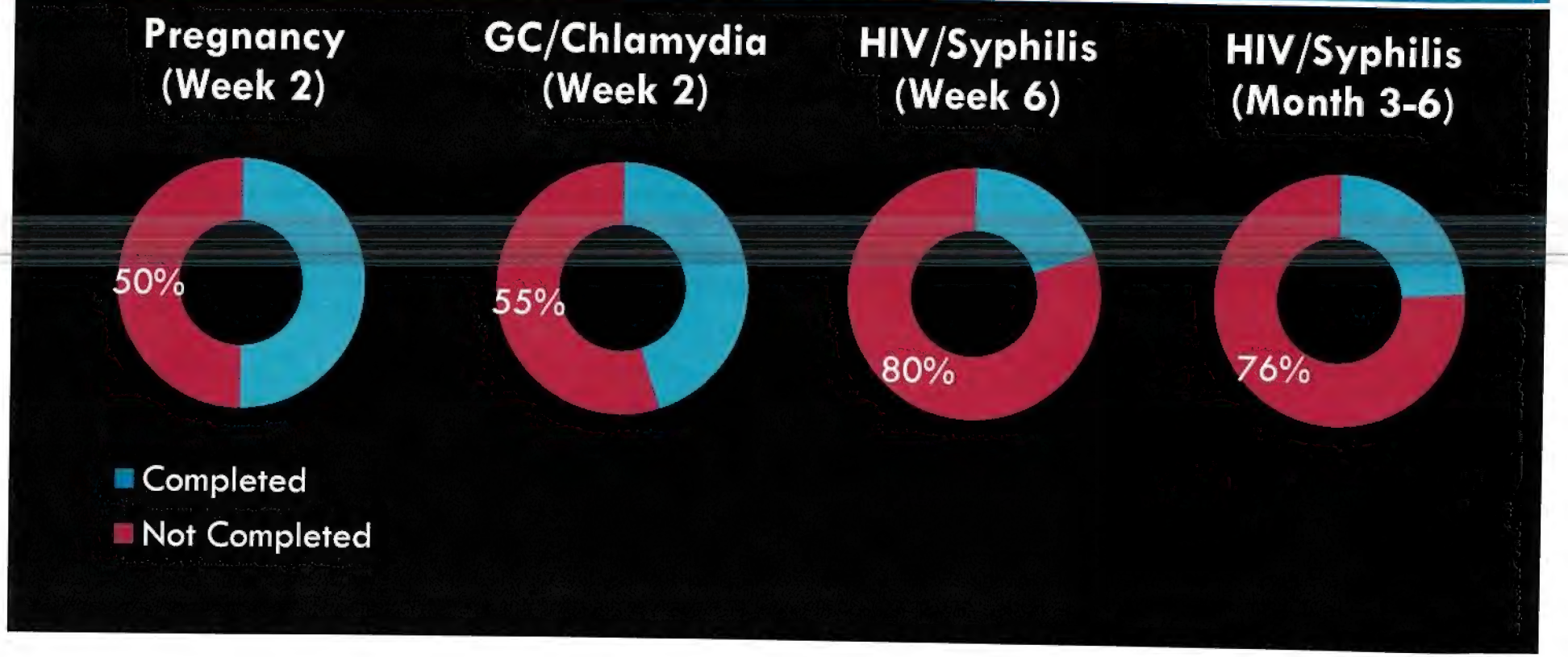
- Retrospective Chart Review
- Clinical Flow Sheet Post Sexual Assault (Korkosz, 2014)
- MHS Management Analysis & Reporting (M2)
  - SA related ICD 9 code
  - Active Duty
  - Clinic on JBSA
  - MHS care for 6 months



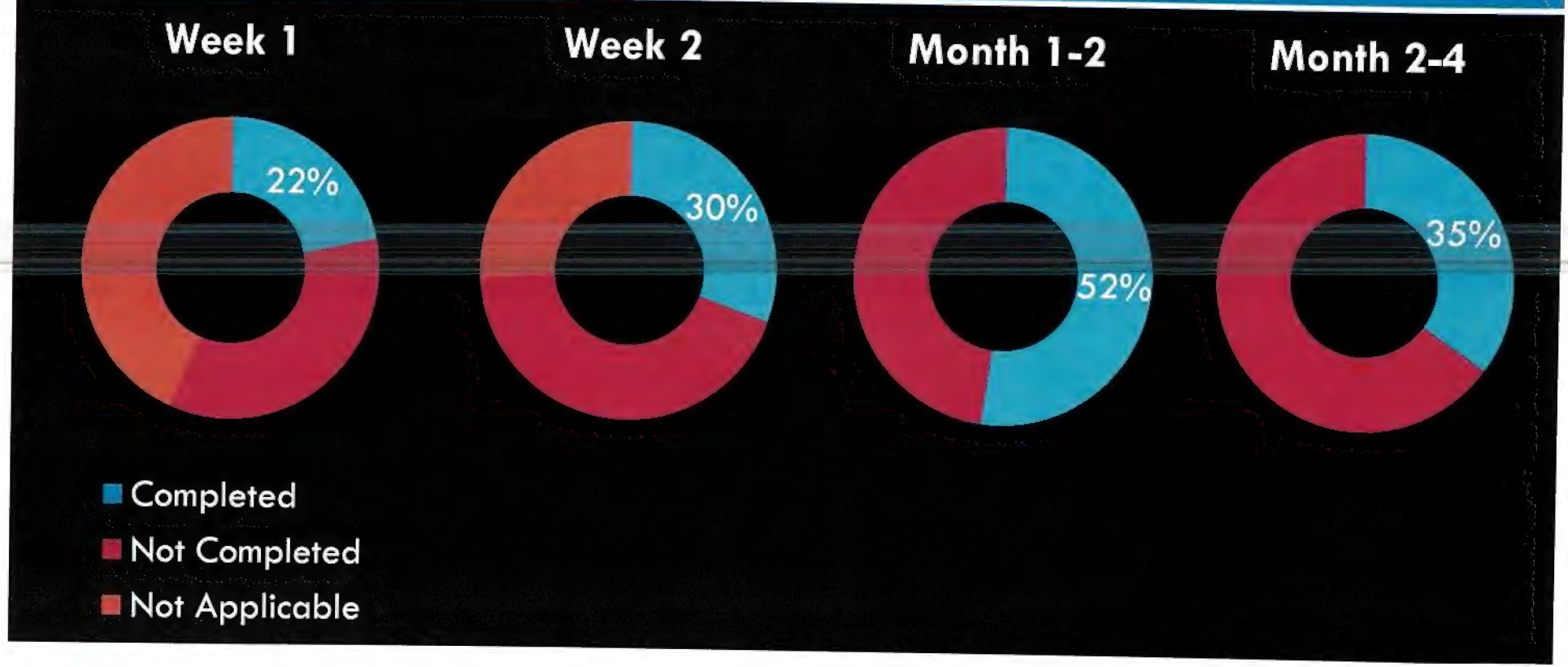
PROCEDURAL STEPS: FOLLOW-UP CARE



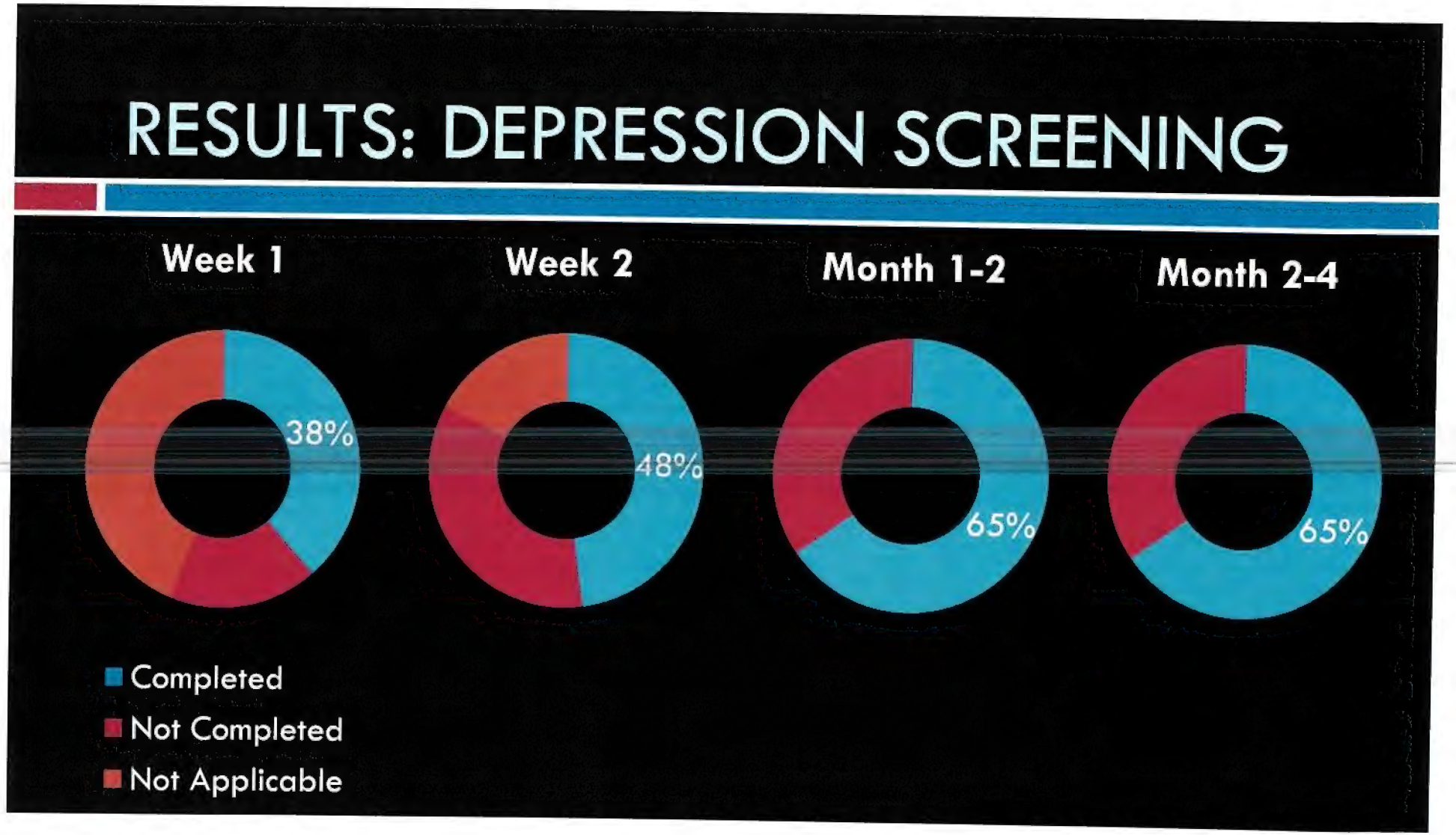
RESULTS: LABORATORY SCREENINGS



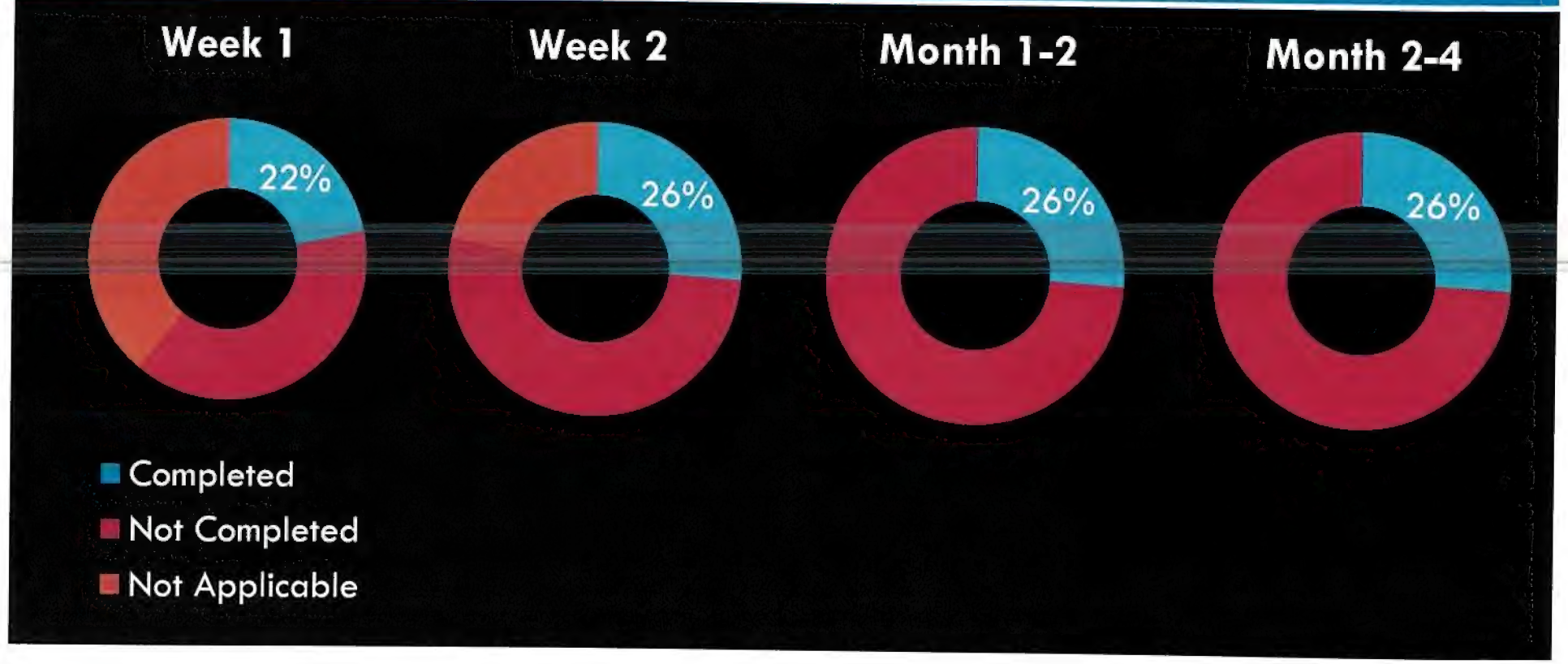
RESULTS: ANXIETY SCREENING

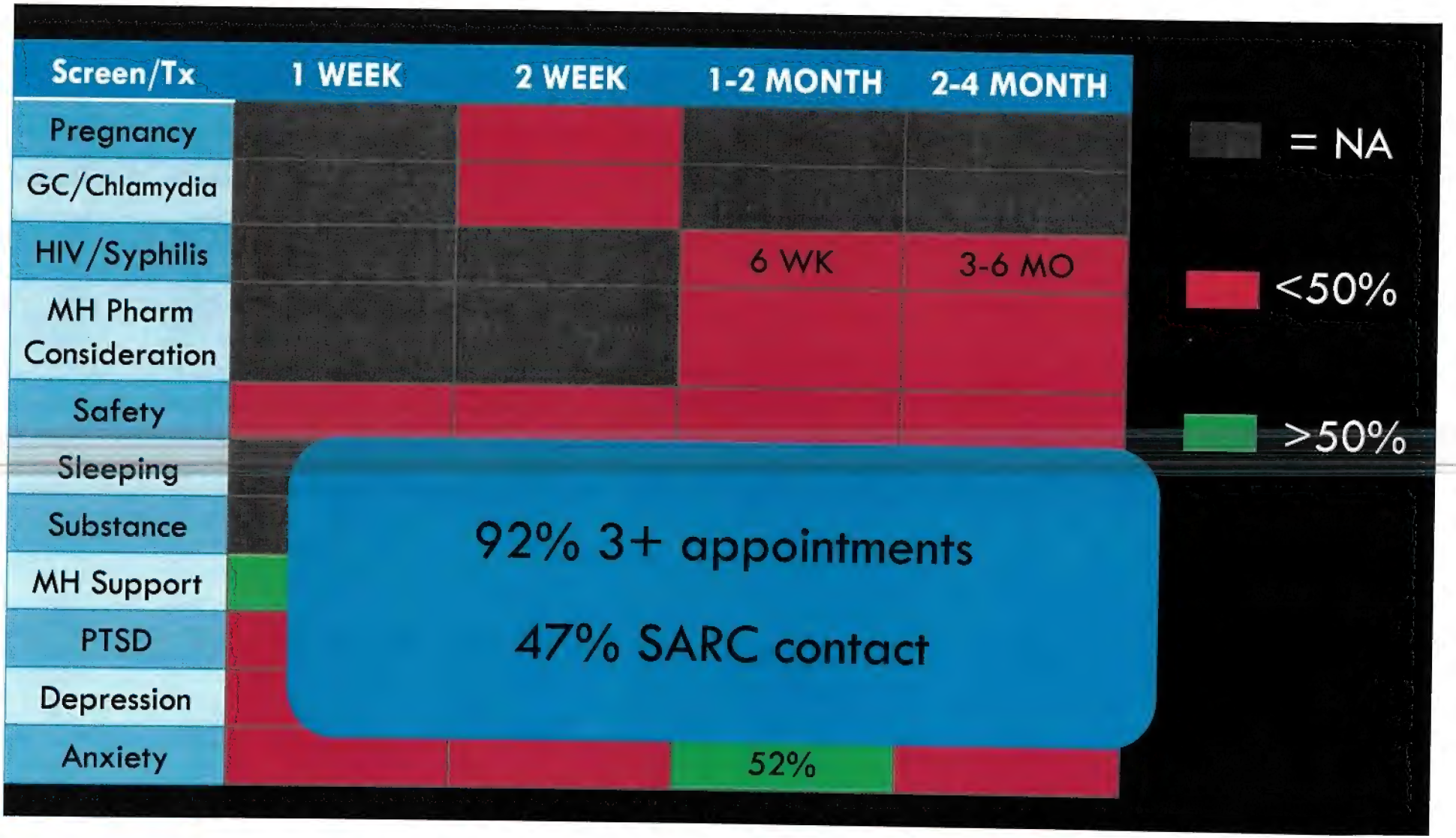


RESULTS: DEPRESSION SCREENING



RESULTS: PTSD SCREENING



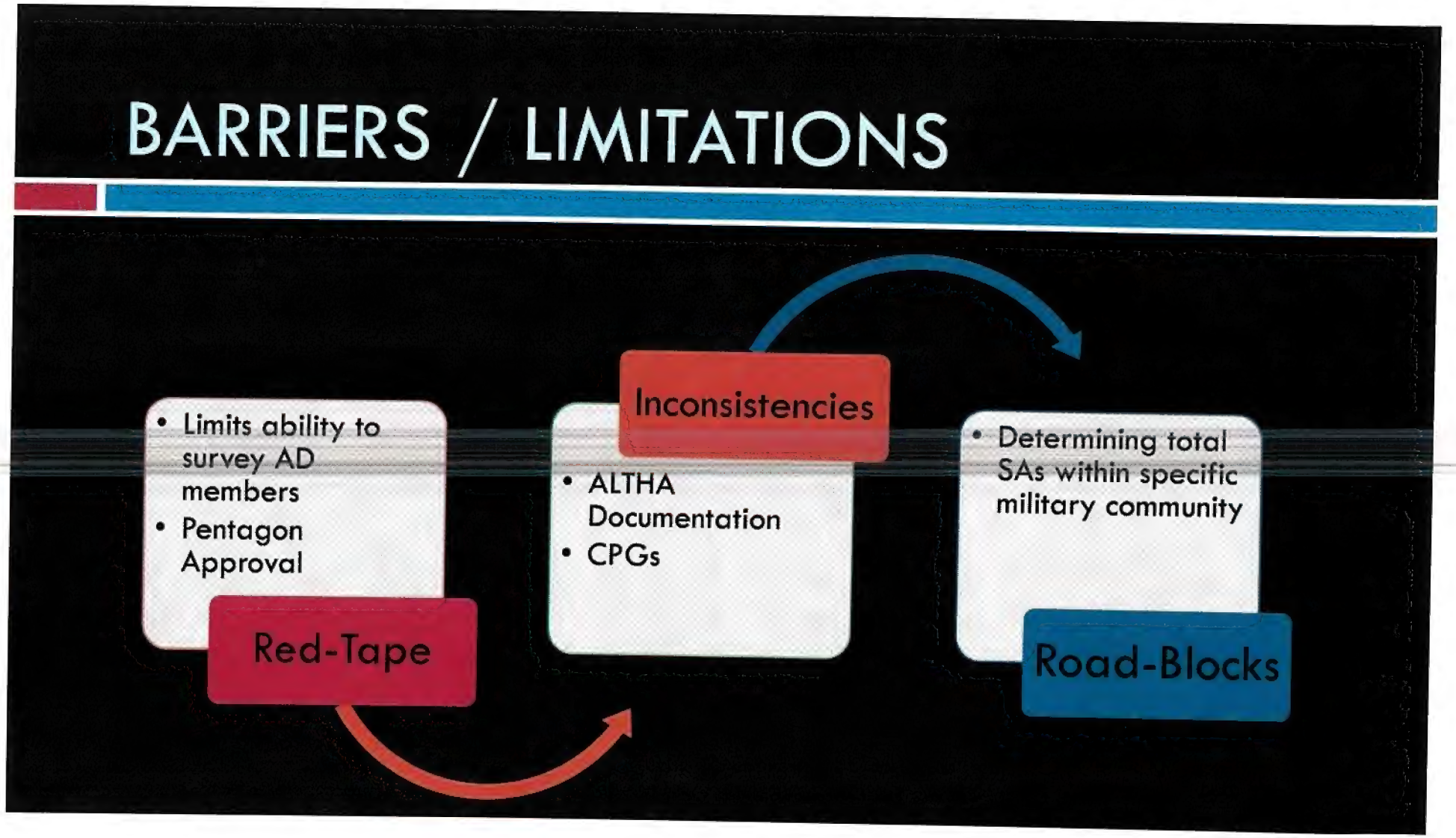

Screen/Tx
1 WEEK
2 WEEK
1-2 MONTH
2-4 MONTH
Pregnancy
GC/Chlamydia
HIV/Syphilis
MH Pharm Consideration
Safety
Sleeping
Substance
MH Support
PTSD
Depression
Anxiety
6 WK
3-6 MO
52%
= NA
<50%
>50%
92% 3+ appointments
47% SARC contact

ANALYSIS: FOLLOW-UP CARE

- No statistical difference in follow up care received by trainees and permanent party members
- Findings compared to literature
- Follow up care policy
- Further investigation & comparison to large NW MTF

CONCLUDING THOUGHTS

BARRIERS / LIMITATIONS



CONCLUSION

- Military SA is a complex issue that needs attention

No screening for victimization during accessions

SA screening not established in primary care

Improve post SA follow-up care

QUESTIONS

THANK YOU

Dr. Diane Seibert – USU
Lt. Col Brian Kittelson – USU
Lt. Col Laura Lewis – USU
JBSA Lackland Leadership
Col. Brenda Morgan – JBSA Lackland
Methods and Analytics – JBSA Lackland
Dr. Victor Sylvia and Dr. Roy Haas – Biostatisticians JBSA Lackland
Maj. Cubby Gardner
Dr. Nathan Galbreath – SAPR Office
Dr. Ann Burgess – Boston University

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KATS, ALEKSANDR Capt USAF AETC 59 TRS/SGVT

From: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Sent: Tuesday, November 24, 2015 5:04 PM
To: KATS, ALEKSANDR Capt USAF AETC 59 TRS/SGVT
Cc: KITTELSON, AMOS B SSgt USAF ANG 114 MAINTENANCE SQ/MXMFM
Subject: RE: Updated provider survey for the DNP group

I spoke to the survey office regarding student status but as long as the survey is "fact based" it does not change the determination--please move forward with your survey as planned.

Col Morgan

Brenda J. Morgan, Col, USAF, NC, PhD
Director, 59 MDW Nursing Research Division JBSA-Lackland TX
210-292-5931

-----Original Message-----
From: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Sent: Thursday, November 19, 2015 3:24 PM
To: KATS, ALEKSANDR Capt USAF AETC 59 TRS/SGVT
Cc: KITTELSON, AMOS B SSgt USAF ANG 114 MAINTENANCE SQ/MXMFM
Subject: FW: Updated provider survey for the DNP group

Capt Kats,

We can discuss when you have time or as needed. Bottom line, no survey number is going to be required.

**Keep this email for documentation should anyone ask later if it was reviewed.

I do suggest you consider their recommendations as the survey will read much better and your findings will be more valid and actionable.

Let me know if you want to offer the providers an electronic option--we could do a survey monkey survey for you...

Good Luck!

Col Morgan

From: TEALER, RENEE J CIV USAF AFPC AFPC/DSYS
Sent: Thursday, November 19, 2015 3:05 PM
To: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Cc: RABAGO, JESSICA CIV USAF AFPC AFPC/DSYS; AFPC/DSYS-Workflow Air Force Survey Office
Subject: RE: Updated provider survey for the DNP group

Good Afternoon Col Morgan,

Although the survey does not require an SCN, I did request a review by one of our OPS analyst as I had concerns with the questions. Ms. Rabago, one of our OPS Analyst reviewed and had recommendations and comments; I've attached her review.

As always our goal is to insure surveys conducted throughout the AF provide reliable, valid and actionable data. With this in mind, please feel free to contact her should you or your POC have any questions about the feedback.

V/r,
Renee

-----Original Message-----
From: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Sent: Wednesday, November 18, 2015 2:26 PM
To: TEALER, RENEE J CIV USAF AFPC AFPC/DSYS
Subject: FW: Updated provider survey for the DNP group

Ms Tealer--
Attached is an updated version of the survey--the wording was changed to request a ranking of the topics...

Col Morgan

From: KATS, ALEKSANDR Capt USAF AETC 59 TRS/SGVT
Sent: Tuesday, November 17, 2015 11:12 AM
To: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Subject: RE: Updated prover survey for the DNP group

Col Morgan,

I have made several more updates to the survey, the 5 questions are essentially the same, attached to this email. Has anything come back from the survey office?

Thank you,

V/r
Aleksandr Kats, Capt, USAF, NC
DNP, FNP Student
Daniel K. Inouye Graduate School of Nursing Uniformed Services University of the Health Sciences
Office: 2200 Bergquist Dr. Rm 7B20
Mobile: (301)675-9409

-----Original Message-----
From: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Sent: Friday, November 13, 2015 5:31 PM
To: KATS, ALEKSANDR Capt USAF AETC 59 TRS/SGVT
Cc: KITTELSON, BRIAN D Lt Col USAF AETC 59 MDSG/SGVT; PROSSER, JENNIFER L Maj USAF AETC 59 TRS/SGVT; ALLEN, MICHAEL P Capt USAF AETC SG05O
Subject: RE: Updated prover survey for the DNP group

Capt Kats--

I sent the below request to m stealer at the AF Survey office.
We should have a response by Monday.

You will notice on the attached I made a note to suggest you revise the instructions to ask the providers to "rank" the following barriers 1-5 with
1 being the lowest (or something similar).

It is just a suggestion.

I will keep you posted....

Col Morgan

Brenda J. Morgan, Col, USAF, NC, PhD
Director, 59 MDW Nursing Research Division JBSA-Lackland TX
210-292-5931

-----Original Message-----
From: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Sent: Friday, November 13, 2015 5:27 PM
To: TEALER, RENEE J CIV USAF AFPC AFPC/DSYS
Subject: Survey Question

As part of an evidence based practice project at the 59MDW, one of the resident practitioners is evaluating adherence to the guidelines/protocols for sexual assault screening and wants to assess for barriers to appropriate screening by family health providers in the WHASC/Lackland clinic, Reid Clinic, and Randolph clinic using the attached 5 questions. The information will be used by the 59 MDW leadership to improve training/revise guidelines.

Will this require an SCN?

As always, thanks for your advice.

Col Morgan

Brenda J. Morgan, Col, USAF, NC, PhD
Director, 59 MDW Nursing Research Division JBSA-Lackland TX
210-292-5931

-----Original Message-----
From: KATS, ALEKSANDR Capt USAF AETC 59 TRS/SGVT
Sent: Friday, November 13, 2015 11:24 AM
To: MORGAN, BRENDA J Col USAF AETC 59 MDW/SGN
Cc: KITTELSON, BRIAN D Lt Col USAF AETC 59 MDSG/SGVT; PROSSER, JENNIFER L Maj USAF AETC 59 TRS/SGVT; ALLEN, MICHAEL P Capt USAF AETC SG05O
Subject: Updated prover survey for the DNP group

Col Morgan,

Attached is the updated provider survey I would like authorization for. The
5 questions focus on the core issues we are looking at with sexual assault screening in military institutions. If the survey office needs to know where I intend to ask these questions: Lackland FHC, Reid Clinic, and Randolph FHC.

Thank you so much for your continued assistance, please let me know if there are any issues or concerns regarding this survey,

V/r

Aleksandr Kats, Capt, USAF, NC
DNP, FNP Student
Daniel K. Inouye Graduate School of Nursing Uniformed Services University of the Health Sciences
Office: 2200 Bergquist Dr. Rm 7B20
Mobile: (301)675-9409